UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 19

PROVIDENCE HEALTH AND SERVICES - WASHINGTON d/b/a PROVIDENCE SACRED HEART MEDICAL CENTER

Employer

and **Case 19-RC-270084**

WASHINGTON STATE NURSES ASSOCIATION

Petitioner

DECISION AND DIRECTION OF ELECTION

Providence Sacred Heart Medical Center ("the Employer") operates an acute care hospital in Spokane, Washington. Washington State Nurses Association ("Petitioner") seeks, by an *Armour-Globe* self-determination election, to add approximately 14 clinical documentation specialists ("petitioned-for voting group"), currently unrepresented, to an existing bargaining unit consisting of registered nurses ("existing unit").

By its Petition, Petitioner maintains the petitioned-for voting group constitutes a distinct, identifiable segment of the Employer's workforce that shares a community of interest with the existing unit. The Employer contends this voting group is not appropriate and disputes the shared community of interest, although it does not dispute that the employees at issue constitute a distinct, identifiable segment of its workforce.

A hearing officer of the National Labor Relations Board ("Board") held a videoconference hearing in this matter on January 6, 8, and 11, 2021.[1] Both parties filed briefs with me after the conclusion of the hearing. As explained below, based on the record, the briefs, and relevant Board law, I find that the record establishes the petitioned-for voting group is an identifiable, distinct segment of the workforce that shares a community of interest with the existing bargaining unit. Accordingly, I have directed the petitioned-for election in this case. Because of the ongoing COVID-19 pandemic, and in agreement with the parties, I have directed that election be conducted by mail.

[1] All dates 2021 unless otherwise indicated.

RECORD EVIDENCE

A. The Employer's Operation

The Employer operates a large medical campus in Spokane, Washington. In addition to the primary 644-bed acute care facility, the campus also includes a children's hospital, a psychiatric unit, and other specialized clinics housed in various buildings.

The existing unit consists of approximately 2,000 registered nurses employed in various functions throughout the Spokane campus. The unit consists of staff nurses, also referred to in the record as general duty staff nurses, and charge nurses in numerous departments throughout the hospital, as well as outpatient clinics. The most recent collective bargaining agreement covering the existing unit is effective January 1, 2020 to December 31, 2022 ("the contract"). Other labor organizations represent other units, such as service and technical workers, and a unit of engineering staff.

Most patients have a third-party provider that is responsible for reimbursing the Employer for services, typically either an insurance company or government program such as Medicare. The process of medical billing, taking the diagnostic information contained in a patient's chart and converting it to information that will lead to full reimbursement, is a multi-step process. The employees at issue, the clinical documentation specialists, are the first step in that process.

B. Community of Interest Factors

i) Organization of the Facility

The Employer's operations in Spokane are organized into departments or units within larger organizational structures. For example, a staff nurse employed in the intensive care unit of the acute care hospital reports to a department supervisor for the unit, part of a hierarchy that reports to the chief nursing officer.

The petitioned-for employees are located in the case management department. The first line of supervision for the clinical documentations specialists is the clinical documentation integrity manager, who is responsible for the employees at issue in Spokane, as well as several clinical documentation specialists at a sister facility in Montana. The clinical documentation integrity manager reports to the director of the case management department. The director of the case management department in turn reports to the Employer's chief financial officer. The case management department contains other, separate groups involved in utilization review, who also have roles in the process that turns the information contained in patient charts and converts that information into reimbursable diagnostic codes.

There is no evidence that any of the staff nurses in the existing unit are employed in the case management department or are employed in departments that ultimately report to the chief financial officer.

ii) The Nature of Employee Skills, Training, and Job Functions

(1) Skills

Clinical documentation specialists are registered nurses required to hold an active nursing license. They are further required to have three years of hospital nursing experience, both requirements that provide the employees with clinical knowledge.

Regarding skills, the clinical documentation specialists must take the information in a patient's electronic chart – a collection of notes, test results, and other diagnostic and treatment information – and ensure that it is presented in a way that will allow for conversion to reimbursable diagnostic codes. This process involves two primary skills: clinical knowledge of medical diagnoses and treatment, to interpret and understand the information in the chart, and medical coding, to understand how the chart must be presented. At hearing, an example was provided detailing how a clinical documentation specialist uses these skills: if a provider (physician, nurse practitioner, or physician assistant) indicated on a chart that they are treating high sodium in a patient the clinical documentation specialist, recognizing that "high sodium" does not correlate to a diagnostic code, would know a change was necessary prior to coding. The clinical documentation specialist would then contact the provider and verify the diagnosis was hypernatremia – the clinical definition of high sodium – a diagnosis that does correlate to a diagnostic code. After the provider provided confirmation the clinical documentation specialist would change "high sodium" to "hypernatremia" in the chart. As shown by this example, clinical documentation specialists must also have communication skills and the ability to work fully with the computer system that manages electronic patient charts.

All the staff nurses in the existing unit are required to have an active nursing license. Staff nurses assess patients and deliver care in a multitude of settings, as varied as the emergency department of the acute care hospital to staffing an outpatient clinic. In each of these settings the staff nurses are utilizing their clinical knowledge to make assessments and document their care in the patient's chart. The record does not contain evidence that staff nurses are required to have knowledge of medical coding.

(2) Training

As noted above, to be hired as a clinical documentation specialist an applicant is required to hold an active nursing license and have 3 years of hospital nursing experience. In addition, pre-hire, applicants take a test that assesses their knowledge of

medical coding. After hire, a clinical documentation specialist is required to attend a training program, provided by a third-party to prepare them for the position.

Staff nurses are required to have a nursing license, current basic life support certification and such additional department-specific certifications and licenses as may be required. The record indicates staff nurses must frequently undergo specific job training related to a specialty, such as when they move between departments within the hospital. There is no evidence that staff nurses have any training related to medical coding.

(3) Job Functions

As described above, the primary job function of a clinical documentation specialist is to review the language utilized in patient charts and identify language that is not compliant with medical billing or is otherwise problematic. When a patient receives care at the Employer's facilities and a chart is created that patient is assigned to a clinical documentation specialist who reviews the chart. Although the specifics of timing are not contained in the record, it is apparent that charts are reviewed almost immediately.

In addition to the billing function, the record also indicates the data integrity function performed by clinical documentation specialists is important for the Employer's research programs and outside review by regulators. An example is provided in the record of a patient whose chart does not indicate an infection at the time of admission, but which identifies an infection later in the patient's stay. The clinical documentation specialist may follow up with the provider to confirm whether this was indeed an infection acquired during the patient's stay (the subject of a possible fine by regulators) or whether the chart poorly documented the incoming patient's condition. A clinical documentation specialist may also, in reviewing the test results and other information contained in a chart, find what appears to be an undiagnosed condition. In this situation the clinical documentation specialist will contact a provider with this possibility, and this has in the past resulted in an updated diagnosis.

In almost all situations where a clinical documentation specialist has questions, they contact the provider. Clinical documentation specialists do contact others providing care, such as a nutritionist, therapist, or staff nurses, and can even issue some orders, but this is not common. Examples provided include a clinical documentation specialist issuing an order for a nutritionist to assess a patient for malnutrition and seeking a wound care consult from a wound care nurse. The record does not quantify how frequently this type of order is issued, other than to suggest it is not a common occurrence. In each of these instances the clinical documentation specialist is sending a message to an on-site provider. Clinical documentation specialists' work is done

electronically and remotely, and they do not physically examine patients, or perform assessments themselves.

Staff nurses perform a wide variety of specific job junctions depending on their department and circumstances, but some constants exist. The registered nurse job description states a staff nurse "…[a]ssesses, diagnosis, plans, implements and evaluates patients care." Further, staff nurses "[m]onitors, records, and communicates patient condition as appropriate." The record also indicates that while all staff nurses are involved in patient care, in contact with patients, not all staff nurses are performing this work in person. The record, as an example, describes the job function of staff nurses in the pre-admit unit, where nurses call patients with upcoming procedures and verify the patient's information, assess the patient based on the information provided, and educate the patient about the upcoming procedure. The pre-admit staff nurse also documents this information in the patient's chart.

iii) Degree of Functional Integration, Contact and Interchange

The extent of functional integration between clinical documentation specialists and the other aspects of the Employer's operation are described above. Staff nurses and others, in all departments and units, make entries in a patient's electronic chart. Every chart is assigned to and reviewed by a clinical documentation specialist.

The record contains minimal evidence of contact between clinical documentation specialists and staff nurses. It is not disputed that clinical documentation specialists typically contact providers regarding charts, but as noted above it may be necessary to contact others involved in patient care. Estimates of how often this occurs varied greatly in the record, with witness estimates ranging from a few times a month to only a few times a year. The record indicates a staff nurse attended a meeting of the clinical documentation specialists on at least one occasion, but this is the exception rather than the norm. Further, the clinical documentation specialists work remotely, and there is no evidence of shared spaces or other casual or social contact with the staff nurses.

Clinical documentation specialists do not engage in temporary interchange with staff nurses. Although they maintain an active nursing license they do not float to departments or units providing direct patient care. However, permanent interchange is common. While the record does not contain exact numbers, the former clinical documentation integrity manager, in that position from 2012 to September of 2020, estimated that eight of the 10 clinical documentation specialists hired in that period entered the position from "patient facing" direct care nursing positions, the equivalent of the staff nurses in the existing unit, either with the Employer or another institution. The former manager herself transitioned to a clinical documentation specialist position after a period of employment as a staff nurse in the Employer's intensive care unit. Clinical

documentation specialists have also left their employment to return to a patient-facing nursing position, although the frequency of this is not quantified in the record.

Terms and Conditions of Employment

Clinical documentation specialists are salaried, exempt employees. Nurses in the existing unit are paid on an hourly basis, and at least some of these nurses are subject to the low census provisions in the contract, which allow the Employer to reduce staffing when the number of patients drops and full staffing is not necessary. Due to the nature of their work, and because they are not covered by the contract, clinical documentation specialists are not subject to the low census provisions and the associated reduction in income. Similarly, clinical documentation specialists do not receive shift premiums and the other provisions that increase the pay of nurses in the existing unit. While the form of compensation differs, the amount of compensation is comparable. Clinical documentation specialists are paid a salary between $69,284 and $152,777. If the wage range contained in the current collective bargaining agreement covering staff nurses, $33.55 to $62.03 an hour, is applied to a 40-hour week over a full year, it is equivalent to between $64,416 and $119,097.

Prior to the current Covid-19 pandemic the Employer had begun transitioning the clinical documentation specialists from office space to fully remote workspaces. With the start of the pandemic that timetable was advanced, and all clinical documentation specialists now work remotely. Consequently, the employees in the unit sought have greater flexibility regarding their specific hours of work, having the choice of starting their day at any time between 6:00 and 8:00 a.m. Because clinical documentation specialists do not work directly with patients, they do not wear scrubs but instead wear business casual attire. While some staff nurses in the bargaining unit must work non-standard schedules including nights and weekends, some do not. Similarly, some are subject to on-call provisions and some are not. While most staff nurses wear scrubs some, like those in the pre-admit staff described above, wear business casual clothing.

Because they are not presently in the existing unit, the petitioned-for employees are not covered by that unit's collective bargaining agreement. As such, certain benefits including their retirement plan, short term disability, and parental leave benefit differ from nurses covered by the contract.

v) Common Supervision

As noted in the section regarding department organization, the clinical documentation specialists first line supervisor is the clinical documentation integrity manager. No staff nurses report to the clinical documentation integrity manager.

ANALYSIS

Board elections typically only present the question of whether employees wish to be represented by a labor organization. However, the Board will, under some circumstances, conduct an election that also resolves a unit placement issue, referred to as a self-determination election. One type of self-determination election is a so called *Armour-Globe* election, directed where a petitioner seeks to add a group of unrepresented employees to an existing unit, derived from *Globe Machine & Stamping Co.*, 3 NLRB 294 (1937) and *Armour & Co.*, 40 NLRB 1333 (1942). An *Armour-Globe* election determines not only whether the employees wish to be represented, but also whether they wish to be included in the existing unit. *Warner Lambert, Co.*, 298 NLRB 993 (1990).

When a petitioner seeks an *Armour-Globe* election the first consideration is whether the voting group sought is an identifiable, distinct segment of the workforce. *St. Vincent Charity Medical Center*, 357 NLRB 854, 855 (2011), citing *Warner Lambert* at 995. Whether a voting group is an identifiable, distinct segment is not the same question as whether the voting group constitutes an appropriate unit; the analysis if a petitioner was seeking to represent the employees in a standalone unit. *St. Vincent* at 855. Instead, the identifiable and distinct analysis is merely whether the voting group sought unduly fragments the workforce. *Capitol Cities Broadcasting Corp.*, 194 NLRB 1063 (1972).

If the voting group sought is an identifiable and distinct segment of the workforce, the question then is whether the employees in that voting group share a community of interest with the existing unit. As stated by the Board, when petitioner seeks an *Armour-Globe* election "the proper analysis is whether the employees in the proposed voting group share a community of interest with the currently represented employees, and whether they constitute an identifiable, distinct segment." *St. Vincent* at 855.

A. Identifiable and Distinct

In *St. Vincent*, the Board concluded a petitioned-for group of employees in a single classification constituted an identifiable and distinct group, appropriate for an *Armour-Globe* election, because the employees were employed in a single department, worked in the same physical location, and shared the same supervision. *Id.* at 855-856. The Board reached the opposite conclusion in *Capitol Cities Broadcasting Corp*., 194 NLRB 1063 (1972), finding the voting group sought arbitrary, and inappropriate for an *Armour-Globe* election, because the employees in the voting group were scattered across various unrepresented departments and lacked such similarities. *Id*. at 1064

Here, this factor is not in dispute. The parties stipulated the clinical documentation specialists in the petitioned-for voting group constitute a distinct, identifiable segment of the Employer's unrepresented employees as, among other items, they share the same supervision, are the only employees employed by the Employer in the clinical documentation specialist classification, and have duties that are distinct from other classifications. Based on the record evidence I accept this stipulation.

B. Community of Interest Factors

In determining whether a community of interest exists, the Board traditionally considers a number of factors, including: whether the employees are organized into a separate department; have distinct skills and training; have distinct job functions and perform distinct work, including inquiry into the amount and type of job overlap between classifications; are functionally integrated with the Employer's other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised. *PCC Structurals,* 365 NLRB No. 160, slip op. at 6 (2017).

Bargaining units consisting exclusively of registered nurses are common, indeed a unit consisting of only registered nurses is one of the units the Board identified in its rule regarding appropriate units in the healthcare industry, 29 C.F.R. Sec. 130.30. However, the Board will not automatically place all registered nurses in any classification in such a unit regardless of function; the Board makes a case-by-case determination applying community of interest factors, with particular attention to whether a registered nurse license is required for the position in question. *Salem Hospital*, 333 NLRB 560 (2001). Regarding registered nurses in utilization review and discharge planning roles specifically, the Board in *Salem Hospital* stated squarely "…the Board has relied on whether the employer requires RN licensure for the position." Id. at 560.

I have addressed each of the community of interest factors below. In doing so, I have noted that the clinical documentation specialists are required to hold an active nursing license, the same license required of the staff nurses in the existing unit.

i) Organization of the Facility

The clinical documentation specialists at issue, within a structure that reports to the chief financial officer, are organizationally separate from the staff nurses, who report to the chief nursing officer. While the record contains relatively little information regarding these structures beyond this basic fact, it does reflect that the clinical documentation specialists are part of the Employer's business operations. However, the role of the clinical documentation specialists is not entirely related to financial matters, as the data integrity work they perform is also necessary for research and reporting to

regulatory agencies. Further, on at least some occasions questions from a clinical documentation specialist to a provider have led providers to update a diagnosis.

While mitigating factors are present, I recognize that the employees in the petitioned-for voting group are reporting within a separate organizational hierarchy than the staff nurses in the existing unit. To the extent separate supervision is a function of department organization I have addressed that in a following section.

ii) The Nature of Employee Skills, Training, and Job Functions

It is undisputed that the Employer requires the clinical documentation specialists to have an active nursing license, the same as required of the staff nurses in the existing unit. The Employer also requires clinical documentation specialists to have "3 years of hospital nursing experience."

Although the title of the classification differs here, I find the clinical documentation specialists at issue in the present case are the functional equivalent of utilization review employees addressed by the Board in prior cases. In *Trustees of Noble Hospital*, 218 NLRB 1441 (1975), for example, the utilization review coordinator reviewed patient charts to verify "efficient utilization of hospital services and the assurance of high quality patient care," and that the "…length of the patient's stay is in conformity with the standards established by the medical staff for the type of illness the patient is suffering from." *Id.* at 1444. In *Salem Hospital*, supra, the case managers at issue were responsible for work "typical" of utilization review and discharge planning employees, including "…interpreting patient charts to determine if the care being given a patient is appropriate and reimbursable…" and other review-related functions. *Id*. at 560. The clinical documentation specialists here are performing essentially the same functions in the same manner.

In *Salem Hospital*, and the cases cited therein, the Board has regularly included registered nurses involved in utilization review roles in nursing units where a nursing license is required. Similarly, the employees have been excluded where a license is not required. Reviewing this case history in *Salem Hospital* the Board concluded "[f]or where RN licensing is not a job requirement, it must be concluded that RN education and training is not necessary to perform the job's functions." *Id.* at 560. I reach the same conclusion here in the affirmative: because the Employer requires clinical documentation specialists to have the same license as staff nurses the same education and training is necessary to perform clinical documentation specialists' job functions. This is strong evidence of a community of interest between the employees at issue and the existing unit.

The Employer does not address *Salem Hospital* or the cases addressing utilization review on brief. Instead, the Employer focuses on the aspects of the clinical

documentation specialist employment that differ from staff nurses, most notably the lack of direct patient care and in-person contact with patients. This is true, but this alone does not distinguish the instant case from the cases cited above where the Board included registered nurses in utilization review roles in registered nurse units. While the Employer may downplay the degree to which licensing requirements demonstrate equivalent skills, training, and job functions between the job classifications, this issue has been persuasive to the Board. Overall, I find the shared skills, training, and job functions strongly support finding a community of interest between the existing unit and the petitioned-for voting group.

iii) Degree of Functional Integration, Contact and Interchange

Clinical documentation specialists perform a review role, all their work is based on the entries made in the patient's chart by providers, staff nurses and others. The record does not identify any work performed by the clinical documentation specialists that is independent of an earlier chart entry by another employee. Accordingly, even though not all chart entries are made by staff nurses, I find a degree of functional integration exists in the work of the clinical documentation specialists and staff nurses.

The record contains minimal evidence of contact between clinical documentation specialists and staff nurses, and I do recognize that this appears to be a distinction between the instant case and some of the Board's decisions addressing nurses in utilization review roles. In *Trustees of Noble Hospital*, supra, for example, the Board referenced the utilization review coordinator as being in "constant contact" with doctors and other registered nurses. 218 NLRB at 1444. It is apparent from the record that the change from paper files to electronic charts has, in the last decade, removed much of the need for utilization review to be physically present in the same space as care providers. While I recognize the difference I find the reduced amount of contact to be more related to a change in how charts are maintained than any factor that would fundamentally change the Board's prior conclusions, and I do not find the lack of extensive contact here makes the cases cited previously inapplicable. Further, while the record here appears to foreclose the possibility of constant or extensive contact between clinical documentation specialists and staff nurses, precisely how much contact exists between the two groups varies widely in the record evidence.

Finally, I find the lack of temporary interchange between the clinical documentation specialists and the staff nurses is outweighed by the very high amount of permanent interchange. It was estimated that eighty percent of the clinical documentation specialists hired in approximately the last ten years have come from staff nurse positions, or their equivalent with another employer. Further, some have left their employment to return to a patient-facing nursing position. I find this strong evidence of permanent interchange strongly favors finding a community of interest exists between the petitioned-for employees and staff nurses in the existing unit.

iv) Terms and Conditions of Employment

Clinical documentation specialists and staff nurses are paid in a generally equivalent range, although in a different manner, salaried vs hourly. Additionally, some staff nurses are subject to contractual provisions that impact pay, such as the low-census procedures and shift premiums. While all staff nurses are covered by the contract, it is not clear from the record if all staff nurses are impacted by these contractual provisions in practice. For example, while a staff nurse employed in the intensive care unit at the hospital will be subject to low census, it is not clear from the record if a nurse employed at an outpatient clinic will have their hours reduced based on that provision. Similarly, a staff nurse employed in the intensive care unit at the hospital may be scheduled on nights and weekends because the department operates on a 24-hour basis. Other staff nurses, such as those employed at an outpatient clinic, do not. These staff nurses work a weekday schedule the same as the clinical documentation specialists.

The Employer largely focuses its arguments regarding this factor on the differences between the fringe benefits of the clinical documentation specialists and the staff nurses, such as different plans regarding retirement, disability and leave among others. I do not find these differences probative because in the *Armour-Globe* context, some employees are represented, and some are not. Focusing on this aspect makes the arguments circular; i.e. it is not appropriate to include the employees at issue in the existing unit because of the differences from the existing unit, but the reason the differences exist is the very issue in the case, the difference in representation status. I agree with Petitioner, citing to *Public Service Co. of Colorado,* 365 NLRB No. 104, slip op. at 1, fn. 4 (2017), that differences in terms and conditions that result from collective bargaining do not mandate exclusions.[2]

Overall, I find the general similarities in wages present some support for finding a community of interest between the two groups, but for the most part this is a neutral factor where differences are either balanced by similarities, or where the differences are caused by representation status.

v) Common Supervision

Here the employees in the petitioned-for voting group are reporting within a separate organizational hierarchy than the staff nurses in the existing unit. The first line or “day-to-day” supervisors differ, and because of these separate reporting structures common supervision does not exist until the highest levels of management. This factor

[2] Petitioner introduced several policies and practices that apply to both clinical documentation specialists and staff nurses. I do not find that these general employment policies, that apply to all or almost all employees of the Employer, are particularly persuasive regarding the community of interest between the two groups, and I have not relied upon those policies in reaching my conclusion.

weighs against finding a community of interest between the clinical documentation specialists and the staff nurses.

C. Conclusion Regarding Community of Interest

I find the clinical documentation specialists share a community of interest with the staff nurses in the existing unit because of their similar skills, training, and job duties, as demonstrated by the Employer's requirement that clinical documentation specialists hold an active nursing license and have 3 years of hospital nursing experience. Additionally, I find factors such as functional integration and the high degree of permanent interchange weigh in favor of this finding. While I recognize the employees in the petitioned-for voting group and the existing unit are located in separate departments and are separately supervised, I do not find these factors are sufficient in the instant case to make the voting group sought inappropriate.

In reaching this conclusion I would additionally note I do not agree with the Employer that the contract covering the existing unit dictates a different result in this case. The Employer argues the recognition language covers nurses employed "in the Medical Center as general staff nurses, charge nurses, supplemental nurses, and resident nurses…," and the clinical documentation specialists do not meet this definition. This is true, but there is no contention that the unit should be clarified to include the clinical documentation specialists, they should be added to the existing unit by way of an accretion, or that they somehow otherwise fit under the existing recognition language. Petitioner is seeking an *Armour-Globe* election to add a voting group to the existing unit, by definition the employees at issue are not *already* covered by the recognition language. To the extent the Employer argues historical exclusion somehow prevents an *Armour-Globe* election it provides no support for this position.[3]

For the reasons described above I conclude that the petitioned-for voting group and the existing unit share a community of interest. Having found the petitioned-for voting group constitutes an identifiable, distinct segment of the workforce that shares a community of interest with the existing bargaining unit, I have directed the election sought.

[3] At another point on brief the Employer posits another version of this argument; because the clinical documentation specialist position has been historically excluded, bargaining history, as a factor in the community of interest test, weighs against inclusion. I do not find the case it cites, *Schuylkill Med. Ctr.*, 367 NLRB No. 100 (2019) has application beyond the accretion context. Again, Petitioner is not seeking to accrete the clinical documentation specialists but is seeking an *Armour-Globe* election.

CONCLUSION

Based upon the entire record in this matter and in accordance with the discussion above, I conclude and find as follows:

1. The rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.[4]

3. The Petitioner is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The following employees of the Employer constitute a voting group appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> Included: All full-time and regular part-time clinical documentation specialists employed at Providence Sacred Heart Medical Center located in Spokane, Washington;
>
> Excluded: All other employees, guards and supervisors as defined in the Act.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the voting group found appropriate above. Employees will vote whether or not they wish to be represented for purposes of collective bargaining by **WASHINGTON STATE NURSES ASSOCIATION.** If a majority of valid ballots are cast for Washington State Nurses Association, they will be taken to have indicated the

[4] During the hearing the parties stipulated to the following commerce facts:

> The Employer, a Washington corporation, with an office and place of business in Spokane, Washington, is engaged in the business of operating an acute care hospital. During the last twelve months, a representative period of time, the Employer had gross revenues in excess of $250,000, and purchased and received at its facilities within the State of Washington goods valued in excess of $50,000 directly from suppliers outside the State of Washington.

employees' desire to be included in the existing unit currently represented by the Petitioner. If a majority of valid ballots are not cast for representation, they will be taken to have indicated the employees' desire to remain unrepresented.

A. Election Details

The election will be conducted by mail. On **Friday, February 12, 2021,** the ballots will be mailed to voters by a designated official from the National Labor Relations Board, Region 19. Voters must sign the outside of the envelope in which the ballot is returned. Any ballot received in an envelope that is not signed will be automatically void.

Those employees who believe that they are eligible to vote and did not receive a ballot in the mail by **Friday, February 19, 2021**, should communicate immediately with the National Labor Relations Board by either calling the Region 19 Office at **206-220-6300** or our national toll-free line at **1-866-667-NLRB (1-866-667-6572).**

Voters must return their mail ballots so that they will be received in the National Labor Relations Board, Region 19 office by **3:00 p.m. PST on Friday, March 12, 2021**. Pursuant to the parties' Stipulation, no ballots will be counted that are received after the due date. All ballots will be commingled and counted by an agent of Region 19 of the National Labor Relations Board on **Tuesday, March 16, 2021, at 1:00 p.m.** with participants being present via electronic means. No party may make a video or audio recording or save any image of the ballot count. If, at a later date, it is determined that a ballot count can be safely held in the Regional Office, the Region will inform the parties with sufficient notice so that they may attend.

B. Voting Eligibility

Those eligible to vote in the election are employees in the above unit who were employed during the payroll period ending **immediately prior to the issuance of this Decision**, including employees who did not work during that period because they were ill, on vacation, or were temporarily laid off.

Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, employees engaged in an economic strike which commenced less than 12 months before the election date, who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote.

Ineligible to vote are (1) employees who have quit or been discharged for cause after the designated payroll period for eligibility, (2) employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or

reinstated before the election date, and (3) employees engaged in an economic strike which began more than 12 months before the election date who have been permanently replaced.

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names, work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the Regional Director and the parties by **Tuesday, February 2, 2021.** The list must be accompanied by a certificate of service showing service on all parties. **The region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition,

if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the election and copies must remain posted until the end of the election. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution.

Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 10 business days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review must be E-Filed through the Agency's website and may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001, and must be accompanied by a statement explaining the circumstances concerning not having access to the Agency's E-Filing system or why filing electronically would impose an undue burden. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review.

Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board. If a request for review of a pre-election decision and direction of election is filed within 10 business days after issuance of the decision and if the Board has not already ruled on the request and therefore the issue under review remains unresolved, all ballots will be impounded.

Nonetheless, parties retain the right to file a request for review at any subsequent time until 10 business days following final disposition of the proceeding, but without automatic impoundment of ballots.

Dated at Seattle, Washington on the 29th day of January 2021.

Ronald K Hooks

RONALD K. HOOKS
REGIONAL DIRECTOR,
NATIONAL LABOR RELATIONS BOARD
REGION 19
915 2ND AVE, SUITE 2948
SEATTLE, WA 98174-1006